State Hawaii:

NONINSTITUTIONAL ITEMS AND SERVICES

The Hawaii Medicaid program uses various methods to determine the rates it will pay for noninstitutional items and services. These methods include the Medicaid reasonable charge (usual and customary), negotiated rates, flat rates, billed charges (that are not out of line), and other methods as determined by the department. The method used depends on the service involved.

waii Medicaid will not pay more than the billed amount or
mum allowed by Federal law and regulation. Moreover,
are established in accordance with the provisions of the Appropriations Act and other applicable State statutes.

The methods used in establishing payments for noninstitutional items and services are as follows:

1. THE MEDICAID REASONABLE CHARGE:

"Medicaid reasonable charge" means an individual charge determination calculated from data collected by the fiscal agent on a covered noninstitutional item or service subject to the Medicaid reasonable charge methodology. In the absence of unusual medical complications or circumstances, the Medicaid reasonable charge is the lowest of:

a. the actual charge of the provider;

b. the provider's usual charge for that service as specified and adjusted by the provisions of the Appropriations Act;

c. the customary charge for that service as specified and adjusted by the provisions of the Appropriations Act;

d. the provider's Medicare reasonable charge (including the economic index and the lowest charge level) for that service for the base year selected by the Legislature; and

e. the maximum amount allowed by Federal law and regulation.

The usual charge is the median fee charged by the provider for a specific service during the profile period selected by the Legislature. The middle charge or the lowest charge which is high enough to include 50% of all charges for that procedure from the provider is selected as that provider's usual charge for that procedure.

The customary charge for a particular procedure is established at the 75th percentile of weighted usual charges for a particular procedure from throughout the State within a given specialty (with the exception of laboratory service which is not specialty-specific). In the absence of sufficient data to develop a customary within a specialty, the customary for a procedure based on charges from all specialties shall apply.

In the absence of data necessary to establish a usual charge, a customary charge, and where no Medicare reasonable

charge exists, the claim will be paid on the basis of the instructions of the department.

An established provider is one who has been in the Medicaid program for 12 months or more.

A new man in town describes a provider who has been in the Medicaid program for less than 12 months. A new man in town, by definition, does not have a previous history of charges to the Hawaii Medicaid program and, therefore, no usual charge can be established. A new man in town is limited to the 50th percentile of weighted usual charges for a given procedure by specialty (again, with the exception of laboratory services) as specified and adjusted in the Appropriations Act.

2. ITEMS AND SERVICES SUBJECT TO THE MEDICAID REASONABLE CHARGE

- Laboratory Services[1]
- X-ray Services
- EPSDT Services
- Family Planning Services[2]
- Physician Services
- Podiatric Services
- Optometric Services
- Other Practitioner Services
- Physician Based Clinics
- Dental Services (including dentures)
- Other Services Specified by the Department

[1]In the case of laboratory services, charges from all specialties from throughout the State are included in establishing the customary charge or conversion factor, as appropriate.

[2]Payments for prescription drugs are made in accordance with 5.b.

3. MEDICAID PAYMENTS FOR OTHER NONINSTITUTIONAL ITEMS AND SERVICES:

a. The following items and services are limited to billed not to exceed Medicare's upper payment limit:

- Durable Medical Equipment
- Hearing Aids
- Home Health Agency Services
- Prosthetic Devices and Appliances except that Intraocular lens implants are limited to Medicare upper payment, limit, unless documentation is provided that actual costs exceed the rate set by the Department or Medicare upper limit of payment.

b. Payments for outpatient hospital services shall not exceed the lowest of:

1. The rate negotiated by the Department;
2. Seventy-five percent of billed charges; or
3. Medicare's upper limit of payment.

c. Payments for an emergency room shall not exceed the lowest of the rate negotiated by the department, seventy-five per cent of billed charges, or Medicare's upper limit of payment.

d. Payments for frames for eyeglasses shall be limited to a flat rate set by the department based on a study of industry prices.

e. Payments for lenses for eyeglasses shall be limited to the lower of billed charges, not to exceed cost plus ten per cent or the Medicare upper limit of payment.

f. Payments for hearing devices shall be the actual claim charge or $300, whichever is lower. Exceptions may be made for special models or modifications.

g. Payments for nurse midwife services shall be limited to seventy-

five per cent of the sponsoring physician's Medicaid reimbursement rate.

h. Payments to pediatric nurse practitioners and family nurse practitioners shall be limited to seventy-five per cent of the prevailing customary Medicaid allowance for pediatric physicians and family practice physicians.

i. Payments for clinic services (other than physician-based clinics) shall be limited to rates negotiated by the department. The types of clinics include government sponsored non-profit, and hospital-based clinics.

j. Payments for teaching physicians shall be limited to rates negotiated by the department and shall be paid to the teaching fund, not to the physician.

k. The Hawaii Medicaid program shall not pay more than the billed amount for any noninstitutional item or service or more than the amount permitted by federal law or regulation.

l. Payment for medical supplies shall be the lowest of the rate set by the department, the estimated acquisition cost (EAC), or Medicare's upper limit of payment.

m. Payments for home pharmacy services shall be the lower of the rate set by the department or Medicare's upper limit of payment.

n. Payments for sleep services shall be the lower of the rate set by the department or Medicare's upper limit of payment.

o. Payments for targeted case management services are based on negotiated rates which take into consideration Medicaid allowable costs.

p. Payments to a facility for non-emergency care rendered in an emergency room shall not exceed:

1. The rate negotiated by the Department;

2. Seventy-five per cent of billed charges; or

3. Medicare's upper limit of payment.

The payment to an emergency room physician for the screening and assessment of a patient who receives non-emergency care in the emergency room shall not exceed the payment for a problem focused history, examination, and straightforward medical decision making.

(q) The upper limits on payments for all noninstitutional items and services shall be established by the department in accordance with section 346-59, HRS, and other applicable state statutes.

4. PAYMENT FOR CERTAIN OTHER NON-INSTITUTIONAL ITEMS AND SERVICES:

a. Payment for prescribed drugs:

1. For single source drugs, shall not exceed the lower of:

A. The billed charged;

B. The provider's usual and customary charge to the general public; or

C. The estimated acquisition cost (EAC) of the ingredient plus a reasonable dispensing fee.

2. For multiple source drugs, shall not exceed the lower of:

A. The billed charges;

B. The provider's usual and customary charge to the general public;

C. The estimated acquisition cost (EAC) of the ingredient plus a reasonable dispensing fee;

D. The Federal Payment Limit (FPL) price plus a reasonable dispensing fee; or

E. The State Maximum Allowable Cost (MAC) plus a reasonable dispensing fee;

3. Over-The-Counter (OTC) drugs shall not exceed the lower of:

   A. The billed charges;

   B. The provider's usual and customary charge to the general public including any sale item which may be available on the day of service;

   C. The allowance set by the program (State maximum allowable costs);

   D. The estimated acquisition cost (EAC) for a drug product plus a reasonable dispensing fee; or

   E. The Federal Upper Limit (FPL) price plus a reasonable dispensing fee.

   Under no circumstances shall the program pay more than the general public for the same prescription or item.

4. Payments for medical supplies shall be made as described in section 3 (l) above.

5. The Federal Upper Limit (FUL) price does not apply if a physician:

   A. Certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient. A checkoff box on a form is not acceptable by a notation of "brand medically necessary" or do not substitute" is allowable.

   B. Obtains medical authorization for medical necessity from the state medical assistance program for specific brands of medication designated by the program.

   In such cases, the payment shall not exceed the lower of

   A. The billed charge;

B. The provider's usual and customary charge to the general public; or

C. The estimated acquisition cost (EAC) of the ingredient plus a reasonable dispensing fee.

6. The estimated acquisition cost for the purpose of this section is defined as the average wholesale price minus 10.5%. Average wholesale price will be derived from the most commonly used packaged size listed in the Bluebook. The estimated acquisition cost means the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of drug most frequently purchased by providers.

7. For the purpose of this section, the reasonable dispensing fee is $4.67 for claims submitted by hardcopy, electronic media claims (EMC) and Point-Of-Sale (POS).

8. The State maximum allowable cost (MAC) for the purpose of this section is defined as the average of the estimated acquisition costs of the three least expensive generics available. At least one of the three products shall be provided by a manufacturer who participates in the Federal drug rebate program.

9. Payment will not be made for innovator multiple source drugs subject to the Federal Upper Limits (42 C.F.R. 447.332(a)) when a less expensive non-innovator multiple source drug is available for dispensing from the pharmacy. Substitution may not be prohibited by Part VI, Drug Product Selection of 328 HRS.

10. The dispensing fee for any maintenance or chronic medication shall be extended only once per thirty days without medical authorization from the medical assistance program. Other appropriate limits regarding the number of dispensing fees paid per interval of time shall be determined as necessary by the medical assistance program.

11. In compliance with section 1927(b)(2) of the Social Security Act invoice reports will be submitted to each qualifying rebate manufacturer and the Department of Health and Human Services Secretary within sixty days after the end of each calendar quarter including information on the total number of dosage units of each covered outpatient drug dispensed under the rebate plan. This report will be consistent with the standard reporting format established by the Secretary and include the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter.

b. Payments for transportation services are limited as follows:

1. Payments for ground ambulance and air ambulance services are limited to billed charges or the Medicare reasonable charge, whichever is lower. In the case of neonatal ground transportation, the upper limit on payment shall be at a rate set by the Department;

2. Except for a recipient who is a stretcher patient, payment for air transportation shall not exceed the inter-island or out-of-state airfare charged the other persons on the recipient's flight, or a contracted amount previously agreed upon between the airlines and the Department for emergency chartered flights. For transportation of a stretcher patient by the scheduled carrier, payment shall not exceed the airfare charged for four seats on the recipient's flight.

3. A round trip airfare shall be paid for an attendant whose services are recommended by the attending physician or are required by the airline. Prior approval of the Department's medical consultant is necessary, except in emergency situations, when the attending physician's authorization is sufficient, subject to the Department's medical consultant's review. In addition, payment shall be made for the attendant's service, provided the attendant is unrelated to the patient. The amount of payment for the attendant's service shall not exceed the following applicable rates:

(a) Leave and return same day $20

(b) Requiring overnight stay $40

4. Payments for emergency air ambulance services shall be based upon prearranged contracted rates between the air carrier and the Department, not to exceed the rates charged the general public or the amounts paid by Medicare, whichever is lowest. The emergency trip shall be authorized by the attending physician using the form designated by the Department;

5. Payments for emergency ground ambulance services shall be based upon prearranged contracted rates between the provider and the Department, not to exceed rates charged the general public or the amounts paid by Medicare, whichever is lowest. Additional amounts shall be paid for life-saving measures administered in the ambulance such as oxygen. The charge shall not exceed the provider's customary charge to the general public, the rate set by the Department, or Medicare's reimbursement level for the same service. Recipients requiring ambulance service shall have the emergency trip authorized by the attending physician using the form designated by the Department or by the medical consultant of the Department;

(6) Payments for medical taxi services shall be by purchase order issued by the branch office and only for trips to or from a physician's office, clinic, hospital, or airport (for covered medical transportation) and the patient's home.

Further limitations on reimbursement for such services include:

(a) No detours or side trips shall be permitted;

(b) The amount of payment shall be made on the basis of metered rates charged the public; or

(c) Payments shall not include compensation for the driver's waiting time at the clinic, hospital, physician's office, or a location of other providers of medical services.